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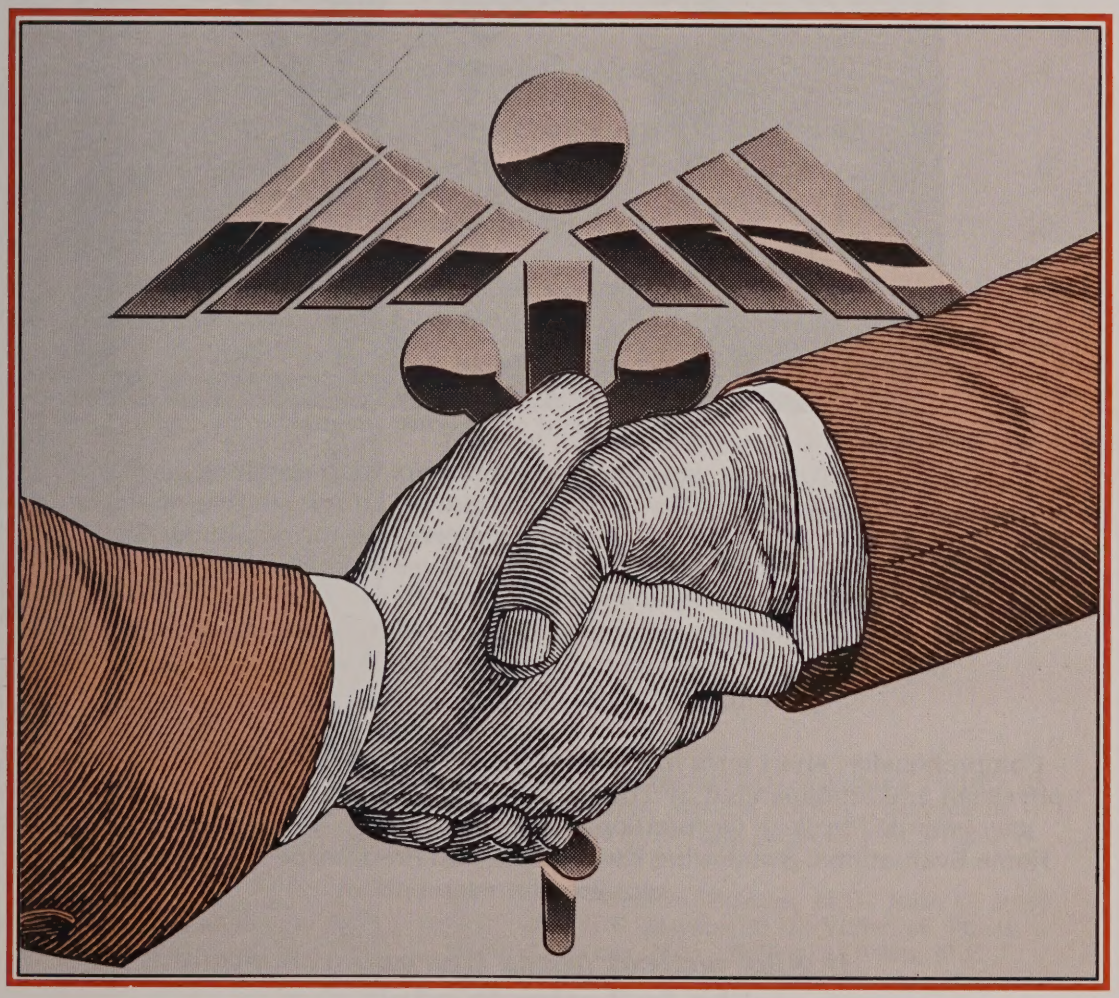

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THE
Hampden Hippocrat

SEPTEMBER-OCTOBER 1994

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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From The Editor

This issue of the Hippocrat offers an article regarding the formation of physician hospital organizations from the anti trust perspective. It is authored by Michelle Feinstein and Arthur Price, who are attorneys with a special interest in health care law from the physician, rather than the hospital, perspective. There is also a summary of local PHO activities. None of the physician organizers most active in local PHO formation have indicated a desire to speak on the record, reflecting how "hot" this topic is at this time.

There is also an article by Dr. Gregory Slachta regarding health care reform from his perspective as a long time participant in national medical politics. He is currently an AMA delegate from the American Urological Association.

Finally there is an eloquent article from Dr. Robert McAfee regarding October as Domestic Violence Awareness Month and a moving tribute to Dr. William B. Coen by Dr. Bernard Bloom.

Brigid Glackin, M.D.
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Doctor William B. Coen

After a long and courageous battle against a lingering illness, Dr. William Coen died on July 15, 1994. He had practiced internal medicine in Springfield from 1938 to 1972, serving on the medical staffs of the Wesson Memorial and Mercy Hospitals. At the Wesson Memorial, he served in many capacities, including chairman of the department of medicine, director of clinical services, and vice-president of medical affairs.

Following the merger of the Wesson Memorial, Wesson Maternity and Springfield Hospitals, he served as associate vice-president for medical affairs at the new Baystate Medical Center.

He was a fellow of the American College of Physicians, American College of Cardiology, and American Board of Internal Medicine. He attended Central High School, the University of Massachusetts pre-med, and Tufts Medical School where he received the M.D. degree in 1935. In 1938 he began his practice of internal medicine. Leaving for the Army Medical Corps in 1941 he served in Washington, D.C. and India until 1946.

Dr. Coen was active in hospital and community affairs and was highly respected for his professionalism in interaction with fellow physicians and patients as well. It was frequently said that at the bedside, or in the office consultations, he never appeared hurried. He made the patients feel that they were most important and required his complete attention,

He served as chairman of the Scholarship Committee of the Hampden District Medical Society for two decades. With the death of Dr. Max Millman, a former Editor of the Hampden Hippocrat, he led the drive to establish the Max Millman Scholarship. He then administered it through the past twenty years, helping allocate funds to worthy and needy students applying to and enrolled in medical schools. The scholarships awarded annually also included funds from the Hampden District Medical Society and the Massachusetts Medical Society. Even during the latter years of his life, when his health was failing, he continued to manage scholarship allocations in a most fair and considerate manner.

Bill Coen was a devoted family man. While conscientiously attending to the demands of a busy solo practice of internal medicine in the Springfield area, including emergencies, night and house calls, he would always make time for his growing family of three sons and his ever-loving and caring wife of over 53 years.

He will long be remembered for his contributions to medicine in the Springfield area, as well as for his support and leadership in developing a healthier community. ■

Bernard Bloom, M.D.

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Comfort And Care Continues

Every patient diagnosed with cancer naturally wants to be cured, and a physician wants to cure every patient, but not every patient is curable. Some physicians feel a sense of failure when they can no longer offer curative measures; some even feel incompetent when faced with such problems. Many physicians are not comfortable dealing with terminally ill and dying patients. It is important to realize that death for these patients is inevitable and medical care should focus on comfort when the patient reaches this stage.

Alicia O. M. Ross, M.D., President

Pain is the most frequent symptom that patients associate with cancer. Pain is so subjective that it can be difficult to assess. A minor discomfort to one patient can be moderate or severe to another. It may be helpful to have the patient grade the pain's severity numerically from 1 to 10. Children can select a pictorial diagram of a face from smiling to tearful to help gauge how much they are hurting.

Patients who have accepted the terminal nature of their illness become very concerned about pain. There is a prevalent dread of dying in agony. Many terminally ill patients would prefer suicide to unrelieved suffering.

There are several interventions available to achieve the goal of making the patient more comfortable. These run the gamut of oral analgesics, intravenous or subcutaneous infusions of opiates, intrathecal route, local nerve blocks, etc. A number of anesthesiologists accept referrals for those patients who cannot be relieved by the above measures. Sometimes pain control can be better achieved by exploring the patient's non-physical problems.

Another fear that patients have expressed is that they will be abandoned by their doctors once a curative treatment is no longer feasible. They must have a recourse when their own doctors feel that they cannot help.

Terminally ill patients ought to be referred to physicians who can deal with the problems of the dying. These patients should then be referred to hospice care. When the patient's doctor is uneasy about terminal care, the hospice physician will be happy to work with the doctor or take over the care if the physician so desires. The doctor will be able to closely monitor the patient because of the frequent contact by the hospice team. Some physicians may feel that they lose control of their patients once hospice referral is made. THIS DOESN'T HAVE TO HAPPEN! If the physician wants to retain control, then the role is enhanced by the hospice interdisciplinary team.

There are a number of hospices in the Pioneer Valley, all of which are directed by physicians. The patient is cared for as a whole, and the medical, psychosocial, financial and spiritual needs are addressed. The families of terminally ill patients are guided through this process with compassion and competence by the hospice team. Patients and their families will never feel abandoned.

As physicians, there are a lot of things we can do to significantly minimize the patient's pain and other symptoms. Hospice can definitely make terminal patients feel cared for, and they will never feel abandoned. ■

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Physician Hospital Organizations: An Anti-Trust Perspective

Michele J. Feinstein and Arthur W. Price, are principals in the firm of Cohen, Rosenthal, Price, Mirkin, and Wernick, Attorneys at Law.

Managed care companies encompass a significant portion of the national health care market place, and are a dominant force in the Pioneer Valley, where approximately two thirds of the patients in the greater Springfield area have health insurance provided through employer based health insurance, the market which is open game in the managed care marketplace. Accordingly, an individual physician, or group practice, can not afford to be foreclosed from approved provider panels, since they stand to lose a substantial portion of their patient volume and mix with the loss of any one contract. Therefore, an individual or group has little bargaining position with which to obtain concessions from a managed care company or third party payor or negotiate out onerous terms in the agreements.

There is a growing trend for physicians and hospitals to band together to increase their ability to win managed care contracts on terms that are reasonable.

It is not surprising then, that there is a growing trend for physicians and hospitals to band together to increase their ability to win managed care contracts on terms that are reasonable. Providers are joining together in record numbers to from alliances (Independent Practice Associations (IPAs) and Physician Hospital Organizations (PHOs)) which can harness collective resources, both financial and otherwise, to negotiate more effectively with third party payors, working together in horizontal and vertical markets. The Massachusetts Hospital Association reported that seventy (70%) percent of Massachusetts hospitals reported implementing at least one physician-hospital organizational relationship in 1992, increased from just forty-six (46%) in 1991.

Currently both Baystate Medical Center and Mercy Hospital are forming PHOs to create new products which integrate the physician and hospital components of health care, enabling these groups to go into the marketplace and compete for managed care contracts with greater negotiating strength. Third party payors appear to welcome this approach since it greatly diminished the administrative costs involved in establishing a physician network and negotiating contracts with each individual physician or group.

The PHO structure, however, is a volatile one, for both practical and legal reasons. From a pragmatic perspective, its constituent members are reluctant partners, fraught with potential conflict and longstanding mistrust; both between physicians and the hospital, and between the physicians themselves; primary care practitioners and specialists, towns and gowns, who must now all work together and compete for the same payment dollar, particularly in the areas of outpatient and ancillary services.

From a legal perspective, due to the collaborative nature of physicians and hospital in a PHO, concerns regarding anti-trust and anti-competitiveness arise. A PHO must be looked at both from the horizontal perspective (a physician joint venture with other competing physicians), and from the vertical perspective (a joint venture with a vertical provider of services, the hospital).

A PHO may have a significant impact on access to health care services. The PHO has the potential to restrain market forces through exclu-

sive dealing or right of first refusal arrangements with its members, possibly excluding competitors from entering or remaining in the market since they may be cut off from referral sources for patients. Additionally, if PHO members apply the PHO pricing to the rest of their practices, anti-competitive price fixing may occur as an overflow from the collaboration which takes place in establishing the PHO contract rate and may also result in informally setting the market rates for the provision of health care services in the locality. A PHO also provides the opportunity for its members to price set; thereby preventing price reductions, and colluding to set minimum market prices.

Another area of anti-trust concern arises from tying. Tying occurs when two separate products are sold together, which can either hinder or assist competition. Illegal tying arrangements occur when a buyer is required to purchase both products whether or not they want both, in order to get the product they do want. In a PHO, physician services and hospital services are marketed together. If purchase of either the hospital or physician service component is conditioned upon purchase of the other service, illegal tying may be an issue.

Perhaps the most troubling implication of the PHO from an anti-trust perspective is the potential for market foreclosure. Depending upon the degree of physician participation in the PHO relative to the overall physician supply in the relevant market, this can be a significant concern. Safe harbor protection is unavailable for PHOs since not only do they fall outside the safe harbor percentages of market penetration as to the horizontal aspect of the venture, but also out of the safe harbor arena altogether, since at present no safe harbor addressing PHO joint ventures exists.

In January of 1994 the United States Justice Department announced plans to issue a policy statement on PHOs, focusing on three areas, market foreclosure, leverage or tying of goods and services and horizontal market power. While this is by no means an exhaustive list of the anti-trust areas of concern for a PHO, they appear to be the areas in which the Department of Justice is currently focusing its attention.

Since at the present time there is no explicit guidance available for PHOs from the regulatory agencies, analysis turns to traditional anti-trust doctrine to determine whether or not there will be anti-trust liability. First, the joint venture must be a bona fide venture (not a sham for collusive dealing) in which integration in economics,

Continued on next page

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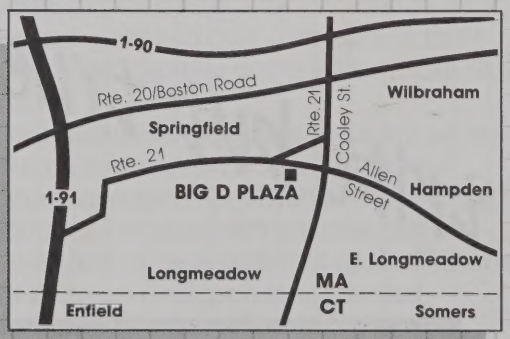

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Physician Hospital Organizations

Continued from previous page

services and/or activities exists. Since most PHOs are established to at least pass minimal scrutiny by not encompassing per se violations, the "rule of reason" standard is employed to review the arrangement. Courts applying the rule of reason standard analyze the joint venture's potential pro-competitive effects and the nature and reasonableness of the venture's restrictions on competition.

1. Price setting. Uniform pricing structure for services within the PHO among competitors is one of the hallmarks of the entity. Where such uniformity in pricing is required to market a product, unanimity among competitors may not constitute an illegal price fixing scheme. A PHO would emphasize that it is able to secure managed care contracts that its members would not be able to secure on their own, and provides a product which insurers are willing to buy, and therefore is pro-competitive. In essence, the argument is that the PHO offers more than the sum of the individual parts of separate contracts with each of its constituent members.

In the past, courts have previously been unpersuaded when considering a similar case by this one factor alone, absent some other distinguishing feature. A PHO relying on this argument alone could be viewed as a price fixing scheme. To avoid such liability, the PHO should have genuine price negotiating mechanisms as opposed to maximum or minimum fee schedules, and should require some element of risk, like capitation and significant withholds to avoid taint as a price fixing vehicle.

2. Integration and Efficiency. Neither the Department of Justice nor the Federal Trade Commission have established an explicit standard for determining whether integration has been achieved. Integration has been found among a variety of factors, including risk sharing, pooling of capital, centralized business operations, joint marketing or consolidation of services and activities. For a PHO, such integration may be found in risk sharing through capitated contracts, withholds, pooling of capital between physicians and the hospital, uniform billing and utilization review. Many PHOs are deficient in establishing integration because they share little risk.

In order to establish efficiency, the joint venture must demonstrate that procedures and practices reduce the cost of providing the service or significantly improve the service, and second that the venture is required to provide or

improve the service. Since the partners maintain their prior businesses, little functional consolidation of services and activities results, and the PHO may actually result in administrative duplication in certain areas (i.e., billing and marketing).

3. Market Share. In communities in which there is more than one hospital which the patients have equal access, PHOs may enhance competition. But if the patients do not view the hospitals as equivalent substitutes for each other, such that if prices rose substantially, or the quality at one declined, they would turn to the other hospital, then the hospitals may not be deemed to be in the same market. The FTC, in analyzing health care cases, looks to see if the power over patient referrals renders other suppliers unable to effectively compete, regardless of the price or quality of their product. Whether or not the PHO possesses this level of market power depends largely upon whether the PHO provides the patient base (i.e., it is also the insurer) or whether it is contracting with the insurer (which provides the patient base).

The commissioner, in reviewing a chiropractic managed care organization which consisted of fifty (50%) percent of the providers in the area, found that the strict numerical analysis was not determinative, finding that the determinative factor in such cases was whether or not the coordination of activities within the joint venture insulate the participating physicians from outside competition sufficiently that they are able to raise prices or reduce services. The court will also look to alternative sources of care in the marketplace in determining the physician's ability to influence the market, i.e., in the case of chiropractors, it might also be relevant to look at orthopedists and physical therapists as alternatives which patients may turn to, to obtain care.

While PHOs were originally contemplated to serve as a vehicle to bid for managed care contracts, they offer the opportunity to address both functional and economic issues within the health care community. The PHO, by its very nature a collaborative venture between hospital and physicians, traditionally mistrustful of each other, creates an environment in which two major factions of the health care marketplace can work together and reach new understandings of the issues each face; thereby improving hospital/physician relations, improving physician education, improving quality assurance and utilization review, increasing strategic planning and may ultimately minimize the self defeating competition between hospitals and physicians, while offering a new, efficient and integrative product to the marketplace of health care consumers.

It is clear that at the present time there is a continuum of risk associated with participation in PHOs. Although there has been significant discussion, both at the federal and state level about providing regulatory relief to the health care industry, such relief has not yet occurred. ■

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Health Systems Reform

Gregory A. Slachta, M.D. is a former president and executive councilor of the Hampden District Medical Society

When asked to write about health systems reform, I first thought of giving a chronology of the past few years starting with the election of Senator Harris Wofford of Pennsylvania on the issue of health care reform and the subsequent election of Hillary, uh, I mean Bill Clinton as President. Then I thought perhaps I should discuss the history of reform dating back to the first half of the century and the Flexner report. More meaningful I thought might be the comparisons of other national systems, their pros and cons. But then I thought it might be more resonable to discuss the simplicity of health care reform. Simplicity you say, if it were so simple it would be accomplished by now. Well, actually the questions are quite straight forward as are the options. What is difficult has always been the decisions. Difficult because of the massive impact on the economy and the politics. It will be my attempt to illustrate the health systems reform options in that format without conclusion as to a solution but rather indicate which are the important issues to the physicians.

> There can be no more important time to become involved politically in your own future.

The questions are:

Who will be covered?
What will be covered?
Who is going to pay?
How much is going to be paid?
To whom will premiums be paid?
Who will be paid for the services?
How will physicians be paid?
How will patients access their physicians?

Who will be covered?
- Employed
- Retired
- Indigent
- All U.S. Citizens
- Illegal Aliens

What will be covered?
- Basic Benefits Package
- Investigational Procedures
- Mandated Benefits
  - Mental Health
  - Pharmaceuticals
  - Long-term Care

Who is going to pay?
- Government-Taxes
- Employers-Benefits
- Individuals-Tax Credits
- Combinations

How much will be paid?
- Global Budgets
- Premium Caps
- Medical Economic Index (MEI)
- Cost of Living Index (CPI)

To whom will premiums be paid?
- Health alliances
- Individual insurance companies
- Health Maintenance Organizations (HMOs)
- Hospital Physician Organizations (HPOs)
- Independent Practice Associations (IPAs)
- Self-insured companies
- Government

Who will be paid for these services?
- Independent Practice Associations (IPAs)
- Hospital Physician Organizations (HPOs)
- Health Maintenance Organizations (HMOs)
- Individual Physicians
- Physician extenders (nurse practitioners)

How will physicians be paid?
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  RBRVS

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Charge-based
- Captitation
- Salary

How will patients access their physicians?
- Total choice
  Specialty care
  Principal care
- Gatekeeper
  Primary Care Provider
  Nurse Practitioner
- Panels-closed or open
- Co-payment for care outside panel

Well, I am sure there are many other questions that require answering and options requiring balancing in the development of a system. Its the decisions that lead to consternation particularly with many of our colleagues urging a Canadian system or single payer system I urge caution. Caution because the elements of universality and free choice of physicians by patients are not guaranteed when negotiating with the government. More likely we would, because of the economic and lobbying strength of insurance industry, have a system of government guaranteed managed care with physician fee controls and no antitrust relief or overhead control (malpractice reform). Physicians should concentrate on six important issues in health systems reform to prevent this from happening...

- **Patient Choice**
- **Maintain autonomy and advocacy role**
- **Fair and reasonable compensation**
- **Elimination of hassle factors**
- **Overhead control**
- **Antitrust relief**

There can be no more important time to become involved politically in your own future. Each and every one of the above issues is being heavily lobbied against. **Patient choice** by managed care organizations. **Autonomy** by hospitals. **Advocacy** by nurses. **Compensation** by the insurance industry and governments. Government bureaucracy continues with over **regulation.** Lawyers continue to oppose **malpractice reform** and hospitals and the insurance industry oppose a level playing field for physicians and our **antitrust relief** efforts. ■

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- malpractice claims due to inadequate informed consent?
- reducing estate taxes, and protecting assets from creditors' claims?
- providing for the orderly disposition of your practice in the event of death or disability?

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Call Arthur W. Price or Michele J. Feinstein to discuss your practice or personal concerns. We're here to help.

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Update on PHO Development In The Pioneer Valley

The Greater Springfield Independent Practice Association(GSIPA) came into existence with the development of Health New England (HNE) as the body which handled many of the "physician issues" involved in the HMO. Although HNE had its own board of directors and medical director, GSIPA through its own board acted on issues of credentialling and setting of fees, and the physician representatives *from Springfield* to the board of HNE were generally the officers from GSIPA's board.

Baystate Health Partners

During the past 18 months, the GSIPA has expanded its purposes beyond Health New England to work with Baystate Medical Center to form a physician hospital organization or PHO. The impetus for this clearly came from the hospital, which declared itself ready, through the cooperation of its own salaried physicians to form a PHO, with or without the GSIPA. The members of the PHO Steering Committee with Dr. Stephen Sweet as chair, felt that the PHO design reflected the "changing landscape of healthcare delivery: purchasers want low cost and quality care; physicians want to continue to have influence and hospitals are facing decreased inpatient stays and bed days."

The proposed organization, Baystate Health Partners (BHP), would have a 50/50 dual ownership by hospital and physicians and would be a non-profit, taxable entity. Physician-funded capital is to be raised by an initial $1,000 capital contribution. The governance structure would be a 15-member Board consisting of 10 physicians and 5 hospital representatives. Actions would require "super majority"–7 of the 10 physician directors and 3 of the hospital directors.

The 545 current physician members of the GSIPA were called to a special meeting on June 21, 1994 to approve the GSIPA's becoming a member of Baystate Health Partners.

Opposition from a portion of the membership centered around the lack of many specifics and the exclusive nature of the PHO contract. The contract specifies that "GSIPA agrees not to represent physicians in another PHO with a non-Baystate Health systems hospital." Concern was also voiced regarding granting the "PHO a right of first refusal on all third party contracts" and on requiring "individual doctors to agree to participate in any contract approved by the PHO" without an independent opportunity to review the fee schedule.

At the June 21, 1994 meeting, 418 members were represented in person or by proxy. Concerns about reimbursement method were voiced. Dr. Sweet spoke for the "vertical integration concept of the PHO: internally, a forum to foster cooperation between differing physicians' constituencies and the hospital, and externally, a vehicle to effectively interact with third party payors."

Dr. Alexander and Dr. Cahill, among others, expressed concern regarding whether there were inferences in the discussion to suggest the introduction of economic credentialling standards and whether due process needs were to be met. Dr. Cahill introduced an amendment that "the PHO contracts and bylaws with incorporation of revisions that address due process concerns expressed at the meeting come before the membership for a vote."

A majority of those able to vote on the question supported this amendment, but it did not pass because the proxies held by the officers of GSIPA were restricted and could not be voted except on the motion regarding GSIPA becoming a member of Baystate Health Partners. That motion passed by 370 to 30.

Members of the Interim PHO Board of Directors are Drs. James Hession, Thomas Magill, Christopher Otis, Thomas Doney, Robert Gerstle, Peter Levine, Jeffrey Cossin, George Lipkowitz, Richard Segool and Stephen Sweet.

Reconsideration

As a result of the lack of consensus evidenced by the June 21 meeting, the GSIPA Board of Directors introduced a "grievance mechanism" into the documents for the PHO formation. It was

also suggested that "a Health Benefit Plan not willing to negotiate with the PHO could notify the physician or group of its intention and then could negotiate with the physician individually."

A further significant change was to open up the nominating process by soliciting "suggestions for various appointments from the membership prior to beginning the nominating process." A second meeting was held on August 18, 1994, to approve these changes. This was apparently done to honor the view of the majority expressed in the amendment at the June 22 meeting which failed on a technicality. Physicians are currently receiving applications to join Baystate Health Partners.

Mercy-Providence PHO

A PHO Formation Committee composed of doctors practiciing at Mercy and Providence Hospitals, has been working during the summer of 1994 with Vincent McCorkle, President of Providence Health System. This group has been meeting in parallel with an IPA Formation Committee. The first general membership meeting of the Western New England IPA (WNEIPA) was held August 17, 1994. The newly elected Board of Directors includes "primary care Doctors" Betsy Brooks, Alphonse Calvanese, Stanley Glasser, William Kiss and Andrew Levin. "Specialists" on the Board are Drs. Robert Kasper, John Sullivan, and Paul Titus. Representing "Ob/Gyn physicians" is Dr. Timothy Fitzpatrick, and Dr. Stephen Klein, represents "ancillary physicians." Elected officers are President: Dr. William Kiss; Vice President: Dr. Paul Titus, Secretary: Dr. Stephen Kline, Treasurer: Dr. Stanley Glasser; and Coordinating Director: Dr. John W. Sullivan. Membership is currently open and membership fee is $250 to be directed to Dr. Sullivan.

Holyoke IPA

The Holyoke IPA has been meeting for some time under the leadership of Dr. Lorne Smith. Membership is $25.

PHO formation has been hampered by the departure of Alex Sletynski, former president of Providence Hospital,and by the proposed merger of Holyoke Hospital with Mercy and Providence Hospitals.

It remains unclear who are the potential customers of a PHO in an area such as the Pioneer Valley which lacks large employers. The hospitals themselves, particularly Baystate, are among the largest employers. In addition, the largest "locally grown" HMO, Health New England, has decided that it needs larger capital reserves to withstand anticipated increased competition from larger, better capitalized HMOs or PPOs and is "for sale." With the anticipated sale of Health New England, it is not clear what the relationship between the HMO "founded at Baystate" and the newly formed PHO will be. ■

In Memoriam

Dr. Malcolm Allan, 83, of the Meadows and formerly of Longmeadow, a former gynecologist in the local area for many years, died Sunday, August 21 in a Springfield nursing home.

He worked in the field of obstetrics and gynecology in Springfield from 1948 until 1986. He served as chief of staff at Wesson Women's Hospital, and as chief of gynecology at the former Springfield Hospital and at Wesson Women's Hospital. He also was a consultant in obstetrics and gynecology at Wing Memorial Hospital in Palmer and Mary Lane Hospital in Ware. He also was an assistant professor at Tufts University Medical School.

Born in Montclair, N.J., he graduated from Bloomfield, N.J. High School. He graduated cum laude from New York University and from Tufts University Medical School.

He served his internship at Rhode Island Hospital from 1938-1940 and was a resident at Providence Lying-In Hospital, the former Boston Lying-In Hospital, and the former Free Hospital for Women in Brookline, both now part of Brigham & Wesson's Hospital in Boston.

He served with the Army Medical Corps during World War II as an orthopedic surgeon with the 102nd and 7th General Hospitals in England and France, and was discharged with the rank of major.

He did pioneer work on the development of Papanicolau smear test at the Free Hospital for Women, which led to the establishment of its cytology department. He also published a landmark paper on ovarian cancer while a resident at the hospital.

He was a member of First Church of Christ in Longmeadow and the Longmeadow Country Club. He held memberships in professional associations including: Diplomat to the American College of Obstetrics and Gynecology, the Inter-Society Cytology Council, the Hampden District Medical Society, the Massachusetts Medical Society, the American Medical Association, and was past president of the Board of the Hampden District Mental Health Clinic. He also was a member of the Baker-Channing Medical Society in Boston, the Alpha Omega Alpha Honorary Medical Society, the Executive Council of Tufts Medical Alumni Association, and the Boston Obstetrical Society.

He leaves his wife, Eunice F. Allan; a son, Douglas S. of Longmeadow; a daughter, Wendy Allan-Johnson of Wilbraham; a sister, Janet Payson of Florida; and five grandchildren and a niece. ■

Lines of Defense: Domestic Violence Awareness Month

Robert E. McAfee, M.D., is President of the American Medical Association, and a practicing surgeon in South Portland, Maine.

America is a nation at war, and the struggle is as close as our own living rooms. Every day we read about gangs battling on our urban streets, the pernicious hold drugs still have on many of our youth, and the continuing fight against AIDS. We are less likely, however, to read about the war played out within the American family, where the front lines lie hidden behind the front doors of our communities. This is the battlefield of domestic violence, where the casualties are enormous and the heroes far too few.

It has been said that heroes are those who do what they can. With so much that physicians can do in this crisis, the hour for quiet heroism is upon us. October is Domestic Violence Awareness Month, a chance for us to take stock of our efforts. As we do, however, we must remember that for the victims, domestic violence is not merely a month long affair – it is a daily, a weekly and all too often, a lifelong struggle.

By the time you have finished reading this sentence, another woman in the United States will have been beaten, battered and bruised by someone she knows. Every 12 seconds, 24 hours a day, 365 days a year, a woman is punched, kicked, slapped – or worse. Every decade, domestic violence kills as many women as the total number of Americans who died in the Vietnarn War.

The damage does not stop, however, with the lives and bodies of women. Domestic violence targets all of the most vulnerable among us, including small children and the frail elderly. Two thousand American children are beaten and starved to death every year, and millions more suffer the horrific effects of ongoing abuse and neglect. It is hard to measure how many millions more victims are ignored or overlooked, because physicians fail to properly identify as many as 95 percent of the victims of domestic violence.

The security of a physician's office may be the only sanctuary the patient can find in a personal hell of violence and neglect. We have a responsibility – not only as physicians, but as citizens and community members – to create the necessary impact to stem this growing Arnerican epidemic.

We must begin with our own awareness of violence in the family. I will never forget the day I met a cardiologist who started a hospital-based treatment center in Kenosha, Wisconsin for abused women.

> "I understand you treat battered women," I said as we were introduced.
> He replied, "And so do you."
> My education began at that instant.

What he meant was that when physicians examine patients with cuts and bruises and broken arms, we may actually be treating victims of abuse.

With a problem as prevalent as domestic violence, the AMA's guidelines for diagnosis and treatment recommend routine screening in the primary care setting. We must be on the lookout, because AMA research shows that 80 percent of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence. Patients trust their physicians. What physicians need are the right tools, and the AMA has them at hand.

In 1990, we formed the National Coalition of Physicians Against Family Violence, now more than 6,000 members strong. The Coalition keeps physicians informed about resources, model programs, speakers and public education materials. Participants receive the AMA Diagnostic and Treatment Guidelines on child and elder abuse and domestic violence, as well as patient materials bearing the message, "When you break the silence, you begin the cure."

It will take more than openness or good medicine to make the cure complete, however. Physicians should become familiar with the range of resources in the community: shelters, legal advocacy, counseling, support groups, crisis hotlines and your state Alliance. Look also to the extraordinary grass roots efforts of our own Federation, where physicians like you have already taken this issue to heart. To turn the tide in a war of this magnitude is going to take every available recruit, side by side, attacking on as

Continued on next page

many fronts as possible. It is going to take lawyers, judges and the police; concemed citizens and local communities; all of us engaged in health care; and the victims themselves – all working together.

To do your share to recognize and treat victims of domestic violence, just keep your professional RADAR tumed on:

- Remember to screen your patients about violence.
- Ask questions such as: "At any time, has a partner hit, kicked or otherwise hurt or frightened you?"
- Document your findings. Information in the patient's chart about "suspected domestic violence" can serve a valuable function in court should the patient seek legal action.
- A physician's documentation validates the victim's allegations.
- Assess your patient's safety. Is it safe to go home? Find out if any weapons are kept in the house, if the children are in danger and if violence is escalating.
- Review options with your patient. Know about referral options.

Remember, the public entrusts us with their care, and many of us have already chosen to be the heroes that their physicial and emotional pain demand. But to gain a beachhead against this national epidemic, there is not a person – or a moment – to spare. As physicians, as citizens, as parents, as sons and daughters, we must work together to break the silence and end the violence, beginning now with Domestic Violence Awareness Month, and throughout this and every year. ■

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The AMA has created a toll-free hotline offering physicians daily, up-to-the-minute updates on the status of health system reform in Congress.

Call the hotline at (800) 833-6354.
In Washington, D.C., call (202) 408-7678.

This service is part of the POWER (Physicians Organized to Work for Effective Reform) Network. Each day, the AMA will update the POWER Network hotline with the latest information on the House and Senate floor debate. Callers will hear a message describing floor activity, its impact on organized medicine and clear instructions on how they can have maximum impact on important upcoming votes.

Physicians and their families are encouraged to contact their senators and representatives to seek support for organized medicine.

The situation in Congress changes daily. This toll-free number will help keep physicians informed on the latest developments.

Callers will also learn how they can add their voice to support organized medicine's agenda.

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In Memoriam

Dr. Haig Bozigian, 84, of West Springfield, and a summer resident of Dennisport, Cape Cod, died Monday August 8, 1994 at Cape Cod Hospital in Hyannis.

He was a longtime physician in this area.

He was born in Troy, N.Y., and lived here for many years.

He was a lieutenant colonel in the Army during World War II, and served in the South Pacific. He was awarded the Purple Heart.

He leaves his wife, the former Patricia Stevick; a son, Haig P. of Redmond, Wash.; two daughters, Stephanie Merrick of Belchertown, and Leslie Stepanis of Harwich; a sister, Dorothy Collins of Arlington, and four grandchildren. ■

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Practice Changes

Arrivals

Dr. George F. Vitek, announces the association of **Dr. John R. Kelley** in the practice of pediatric and adolescent medicine at 2341 Boston Road, Wilbraham.

Dr. Kelly A. Instrum has joined the Orthopedic Practice of Drs. Victor Panitch and Thomas Rossi at 10 Hospital Drive, Holyoke. Dr. Instrum specializes in sports medicine and shoulder and knee surgery.

Dr. Richard A Shuman has joined the internal medicine practice at Medical West, Chicopee. He was previously a staff member at Dartmouth–Hitchcock Medical Center in Lebanon, NH.

Dr. Anne Koss has joined the internal medicine practice at Medical West, Agawam.

Dr. Ilan Bornstein has joined Medical West, Springfield in the practice of obstetrics and gynecology. He was formerly a resident at the University of Maryland.

Departures

Dr. Howard Eisenberg has left the practice of pulmonary and critical care medicine and relocated to Florida.

Other Changes

Dr. Christine A. Sickle has left the pediatric practice at 2341 Boston Road, Wilbraham. She has joined the practice of Dr. Joseph Stirlacci at Sumner Pediatrics, 264 Sumner Avenue, Springfield.

Drs. Sertrag Zacarian, Joseph Corcoran, Ronald Nadel, Arthur Sher, Stanley Glazer, Nadine Wenner and **Jay Hendrix,** have joined their practices of dermatology. They now practice as New England Dermatology with their main office at 3455 Main Street, Springfield. ■

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Subramani Seetharama, M.D.
233 Carew Street
Springfield, MA 01104

Born: June 3, 1958
Premed: Kirorimal College, Delhi, India 1975-1976
Medical: Armed Forces Medical College, Pune University 1976-1981
Internship: Command Hospital, Tafa Hospital, India January 1982-December 1982
Ohio Valley Medical Center, West Virginia 1989-1990
Residency: St. Francis Medical Center, Pittsburgh, PA 1991-1994
Kasturba Medical College, Manipal, India January 1983-July 1983
Specialty: Physical Medicine/Rehabilitation

Enrico Caiola, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 1, 1968
Premed: Canisius College, Buffalo, New York 1986-1990
Medical: SUNY-Buffalo School of Medicine, New York 1990-1994
Internship: Baystate Medical Center 1994-Present
Specialty: Internal Medicine/Pediatrics
Intern

Craig E. Kannel, M.D.
2377 Boston Road
Wilbraham, MA 01095

Born: April 3, 1964
Premed: Wesleyan University, CT 1982-1986
Medical: University of Rochester, NY 1986-1990
Internship: University of Rochester 1991-1993
Chief Residency 1993-1994
Specialty: Internal Medicine

James G. Kohlroser, D.O.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: April 29, 1968
Premed: Siena College, New York 1986-1990
Medical: New York College of Osteopathic Medicine 1990-1994
Internship: Baystate Medical Center 1994-Present
Specialty: Internal Medicine
Intern:

Eric M. Liederman, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 20, 1963
Premed: Dartmouth College, NH 1980-1984
Medical: Tufts University Medical School 1985-1989
Internship: Oakland Naval Hospital 1989-1990
Residency: University of Pittsburgh 1993-1994
Baystate Medical Center 1994-Present
Specialty: Internal Medicine
Resident

Thomas S. Pisano, M.D.
Charles River Hospital West
350 Memorial Drive
Chicopee, MA 01020

Born: June 26, 1956
Premed: Fordham College, New York 1975-1979
Medical: Universidad Del Noreste, Mexico 1979-1983
Internship: State University of New York (HSCAB-Fifth Pathway) 1983-1985
Residency: State University of New York (HSCAB) 1985-1989
Specialty: Psychiatry

New Members Welcome

Continued from page

Mitsu A. Kee, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 15, 1968
Premed: Mount Holyoke College, MA 1986-1990
Medical: State University of New York at Stonybrook 1990-1994
Internship: Baystate Medical Center 1994-Present
Specialty: Pediatrics
Intern

Cecelia T. Yu, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 4, 1967
Premed: Dartmouth College, NH 1986-1990
Medical: Dartmouth Medical School 1990-1992
Brown University 1992-1994
Internship: Baystate Medical Center 1994-Present
Specialty: Obstetrics/Gynecology
Intern

Gregory W. Little, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 3, 1967
Premed: The University of Texas at Austin 1985-1989
Medical: University of Texas Health Science Center at San Antonio 1990-1994
Internship: Baystate Medical Center 1994-Present
Specialty: Internal Medicine/Pediatrics
Intern

Michael K. Soeder, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: April 21, 1967
Premed: State University of New York at Buffalo 1985-1989
Medical: State University of New York at Buffalo 1989-1993
Internship: Baystate Medical Center 1993-1994
Residency: Baystate Medical Center 1994-Present
Specialty: Internal Medicine/Pediatrics
Resident

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